quently returned to his employment. When last heard from he complained of some pain in the ankle-joint during cold or damp weather, or following excessive walking. (See Figure 5 (B)).

DISCUSSION

E. W. CLEARY, M. D. (177 Post Street, San Francisco) — I have read with interest and profit Doctor Prince's painstaking analysis of this very important group of fractures. So completey has he covered the subject that not much is left to be said.

Fractures involving the major weight-bearing joints carry always the possibility of such serious crippling that the surgeon confronted with such an injury should be at once upon his mettle.

In fractures about the ankle, particularly the distortion produced at the moment of injury, rarely persists until the patient reaches the surgeon. Either through the strong natural tendency of the tissues to return to a normal relation or to the immediate interference of someone who happens to be on the ground, a partial reduction occurs before the surgeon appears on the scene. For this reason, it sometimes happens that the extent of the lesion is underestimated and the surgeon fails to visualize the degree, as well as the direction of primary distortion. He may, on this account, fail in his manipulations to secure reduction, because he does not "unlock" tissues by the important maneuver of reproducing the primary distortion and beginning the reduction from that point.

Many of these so-called fractures are really combinations of fractures and dislocations, and the attendant ligamentous lesions are a very significant factor. I recall the startling degree of ligamentous tearing, which I found present in the first extensively compounded fracture involving the ankle-joint which fell into my hands. Seeing the torn ligaments is very impressive, but it is well to bear in mind that the tearing may be just as extensive, though the elastic skin remains intact. Good bony reposition may be obtained, by manipulation, a considerable time after injury, even after primary swelling has subsided, but a good restoration of badly torn ligaments is usually not possible unless the reduction is completed very early.

H. D. BARNARD, M. D. (2417 South Hope Street, Los Angeles)—In a number of fractures about the ankle I have encountered cases which presented marked disturbance of the normal relationship of the leg alignment prior to the fracture, the mortise of the ankle being rotated outward up to as much as 40 degrees or more from its normal relation to the knee-joint. This resulted, as was pointed out several years ago by Hoke and others, in the ankle-joint operating in one plane and the knee-joint in another, despite the fact that they are joints superimposed upon one another, and to obtain the greatest possible mechanical efficiency should operate in the same plane.

I have several times wondered, in inspecting these cases as they present themselves as a final after-result, as to whether one would be justified in attempting to reduce any of these torsion deformities of the limb at the time of reduction of the fracture. I mention this consideration only to emphasize the opinion expressed by Prince that the most accurate anatomical reposition of the relationship prior to fracture is to be most desired.

The surgeon is not justified in being influenced by the presence of rotation deformities prior to fracture from this one main factor, proper attention to which is so essential to success.

A small percentage of these fractures yield an unsatisfactory final result, apparently, when all of the essential factors as enumerated by Prince have been carefully carried out. The pathology in these unsatisfactory cases is probably similar to the cases of prolonged painful feet, following tarsal fractures involving the subastragaloid joint. Disturbances in the normal contour of the joint surfaces, involving the sliding mechanisms, probably remain uncorrected to some extent even in the hands of the most expert. The persistence of pain and disturbance in the tarsal fractures, involving the subastragaloid joint over such a long period of time, has been my reason for adopting as a routine the arthrodesing operation through the subastragaloid articulation.

Unfortunately, a similar answer cannot be applied to the persistent painful after-results of the type of fracture under discussion by Prince. I heartily concur with the author in the belief that the open operative procedures are indicated in cases of fractures about the ankle followed by union in malalignment.

ACRODYNIA

A. J. SCOTT, JR.*

DISCUSSION *by William Palmer Lucas, San Francisco; Robert G. Sharp, San Diego; Clifford D. Sweet, Oakland.*

ACRODYNIA, known also in Australia as the "pink disease," is not very common anywhere. A few sporadic cases have been reported from different localities, but none from Southern California. It has been known in France since 1828, where it was epidemic for two years, and around fifty thousand persons were affected. Acrodynia has been confused with pellagra, but careful study has differentiated the two diseases.

In this country, J. D. Bilderback was the first to describe the condition; followed later by William Weston and Albert H. Byfield, and John Zahorsky has discussed a number of these cases. Following the work of these men, case reports have come in from various parts of the country. (For a complete account of the early history and bibliography, see Abt's System of Pediatrics, Vol. II, p. 986.)

The consensus of opinion is that there is no specific etiology of acrodynia, but it is probably infectious and not contagious. The disease runs its course, from a few weeks to several months, with remissions and exacerbations.

The following case report with pictures was submitted to Drs. Bilderback, Weston, and Zahorsky.

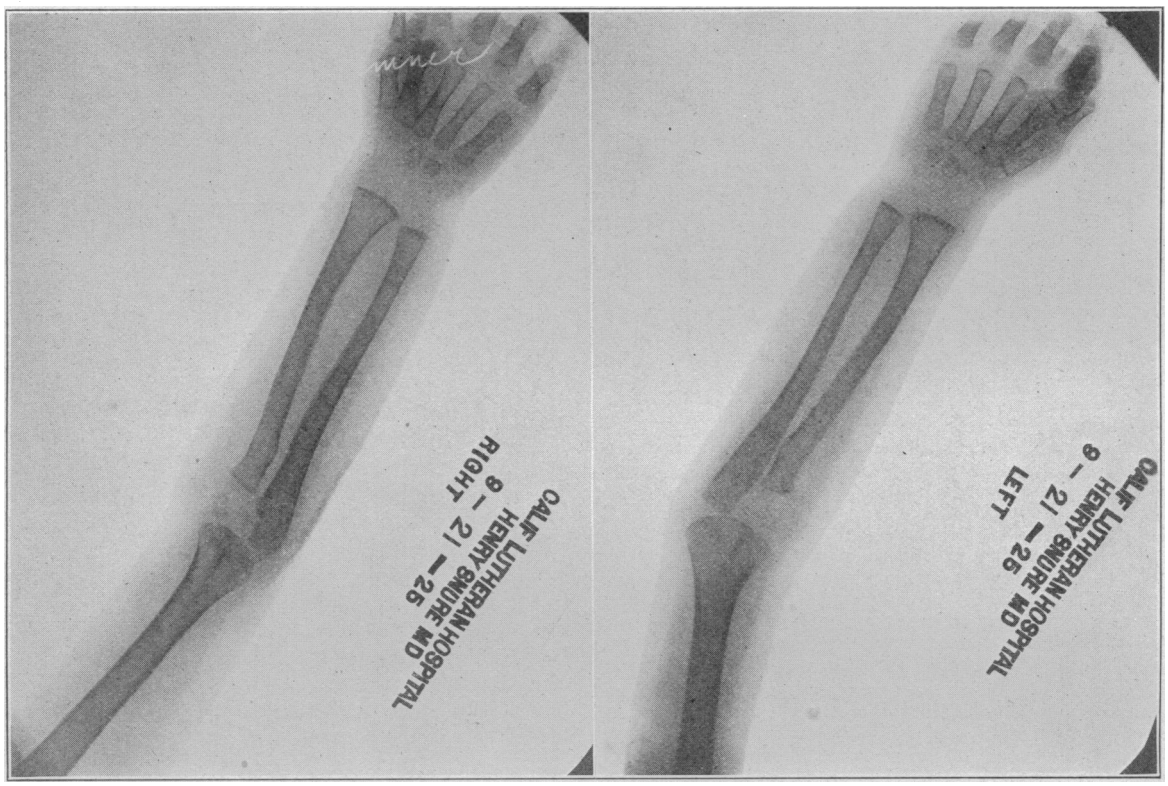
Dr. Bilderback wrote: "This is undoubtedly a case of acrodynia. I shall be glad to keep the report of this case."

Dr. Weston wrote: "I unreservedly concur in your diagnosis that this is a case of acrodynia. I base my opinion upon the blood findings, the nature and situation of the rash, the desquamation and sweats, the stomatitis and bleeding gums, the marked restlessness, nervousness and insomnia, loss of appetite, and I would judge from the photographs that photophobia is present. In considering acrodynia, we must not lose sight of the fact that it is a protean disease, presenting in different localities and at different seasons very different types of symptoms. This observation was made by the French authors in the early epidemics observed in France, and has since been observed in Australia, New Zealand, the West Indies, and the United States."

CASE REPORT

A male of 19 months; the second child; a normal delivery; birth weight, 9¾ pounds; breast-fed, nine months.

* A. J. Scott, Jr. (1401 South Hope Street, Los Angeles). M. D. University of California (Los Angeles Department), 1909. Practice limited to Pediatrics. Hospital connections: Los Angeles General, California-Lutheran, Anita M. Baldwin, Hollywood, and White Memorial hospitals. Appointments: Member California State Board of Health; Professor Clinical Pediatrics, College of Medical Evangelists, Los Angeles. Scientific organizations; Member of Los Angeles Obstetrical Society; Southwestern Pediatric Society; Fellow of the American College of Physicians. Publications: Several articles in state and national medical journals.



There is a history of lues in the family which otherwise has no bearing on the present condition.

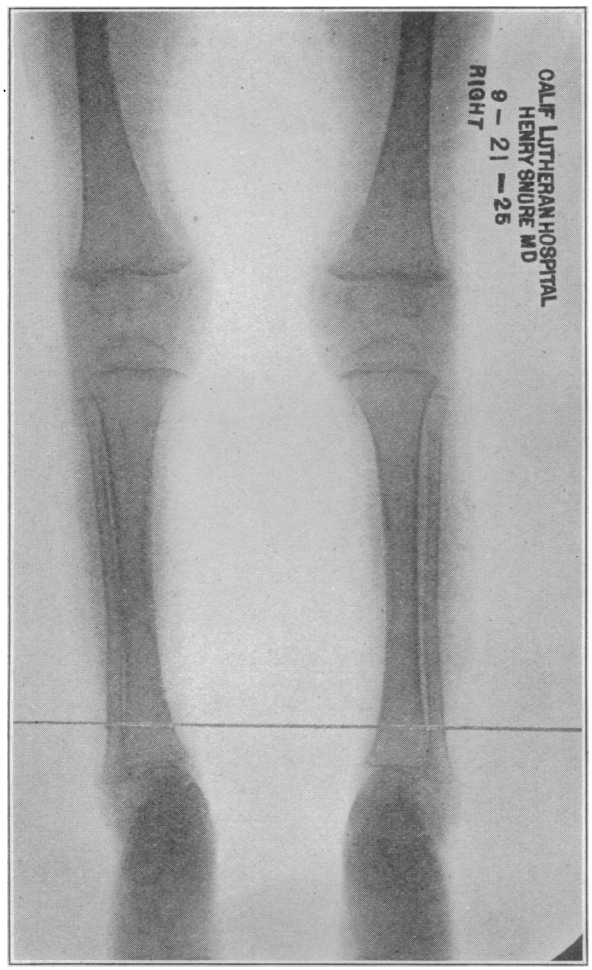
The patient was first admitted April 22, 1925, because "he did not sleep well." He had a good appetite, and bowels were regular. His disposition was good. Physical examination that date showed a normal boy with clean skin and firm muscles; body weight, 27½ pounds; height, 32 inches; temperature, 98.6. May 5, 1925, the child was brought into the skin department with a rash on the abdomen and back, which was diagnosed as a toxic rash. His temperature was 99, and the weight 26¼ pounds, a loss of 1¼ pounds since previous visit.

May 18, 1925, the skin department reported a sparsely generalized punctate or blotchy macular rash with desquamation of palms and soles, and abdomen somewhat tender. The boy was referred to the medical division with a temperature of 100, and a history that this condition began six weeks previously with an eruption, first on the abdomen and then on the back, of small red papules; about one week later it started on the soles of the feet as large blebs. The feet began to desquamate, leaving a reddened base with minute vesicles and desquamating areas. There was very little fever. The child was cross and nervous. Sweating started two weeks before our examination, and sleep was poor. Three days before seeing us he had been stuporous, and had a tendency to throw his head backward. The history shows that prior to the present trouble there was a fondness for apples, water of vegetables cooked in closed vessel, and one or two soft-cooked eggs daily. Three days before the child had been taken off milk and given orange juice and meat broths, with improvement of the skin. On June 4, 1925, his temperature was 98, and the weight 23¼ pounds. Feet were still itchy, but not perspiring as much. Hands very much the same. No bleeding of the gums and no stomatitis. Was not sleeping well at night. Appetite was better. Hands and feet were cold, desquamation continuing. The child was very listless and irritable, and did not like being handled. Crawled around on the bed, seeming to find difficulty in finding a comfortable position. Would not eat anything except orange juice and milk. On June 11, 1925, the temperature was 98.6; weight, 22½ pounds. Hands and feet were improved. The rash was clearing. Stomatitis still present, but gums were not bleeding. Mother said she had noticed some blood. Two days before, the baby passed some fine sand from the bladder. Bowels were normal, and appetite improved. Had slept better the last two nights, but the mouth condition had disturbed him. Ordered chlorate of potash mouth wash after meals. On June 25, 1925, the temperature was 100.4, and the weight 21 pounds 14 ounces. Sleep was poor. Bowels somewhat costive, requiring enemas. The appetite was poor, would drink only milk and not eat. He gritted his teeth. Was nervous and restless at night. Had one sore in mouth, but gums were not bleeding. He was getting very emaciated. Ordered syrup hydriodic acid, fifteen drops three times a day.

The child then dropped from sight because they lived out of town, and some weeks later our social service department called to find out the reason for not returning. The mother stated she had taken him to an osteopath for four weeks with a gradual losing of ground, then to a chiropractor who gave quartz-light treatments and orange juice; then because of a developing pulmonary edema and suppression of the urine, called in Dr. J. J. Allen, who relieved the acute edema and started the kidneys to functioning; then began hypodermics of iron every other day and a diet of sweet milk, eggs, and brown bread toasted hard. The boy gained three pounds in two weeks, and on the stopping of iron gained only one-quarter pound in three weeks; on starting iron again he gained one-half pound a week. The diet was increased, and on September 21, 1925, he was brought back to the clinic. He was sleeping well. Bowels were moving daily. Had a good appetite, and was stronger. His body was practically clean, though the hands were still a little rough and itched some.

On April 4, 1925, Wassermann negative. On June 4, 1925, blood count: leukocytes per c. mm. 13,200; small lymphocytes, 45.5 per cent; large mononuclears, 2.5 per cent. Polynuclear: neutrophiles, 52 per cent.

On September 21, 1925, x-ray report, as follows: X-ray of knees, ankles, wrist, and elbows show no definite abnormality. There seems to be lack of calcium content in the bones extending for one-half to one inch from joint surfaces, not very marked, however. Ossification centers are normal for twenty-three months, except possibly that of the lower epiphysis of radius on right side, which is not present. Left one sharply defined; time for appearance of this center is given by most authors as two years



* The horizontal line is the result of folding of the radiograph.

of age. Isadore Cohen states his experience is that they appear the first year.

Treatment—The sustaining of strength and good nutrition, and the allaying of the intolerable itching, are the most important factors in treatment. There is no specific therapy. What one man thinks helps or cures one patient may have no effect on another. Rodda reports that tonsillectomies result in improvement in these patients, and Sweet uses quartz light. We noted improvement some weeks and not in others. After his severe relapse when under the care of the osteopath and chiropractor, Allen got good results by iron injections. This may be merely a coincidence, but well worth considering.

DISCUSSION

WILLIAM PALMER LUCAS, M. D. (490 Post Street, San Francisco)—During the past ten years, the attention of the medical world has frequently been called to new symptom complexes. Some of these have later been shown to be reappearances of diseases which had been dormant for some time, but under favorable circumstances burst out in epidemic fashion. Such, for example, are influenza and epidemic encephalitis. Other symptom complexes which are apparently without previous recognition must be accepted as new disease entities. The reports of Longcope, and Sprunt and Evans, on infectious mononucleosis would indicate a hitherto undescribed disease.

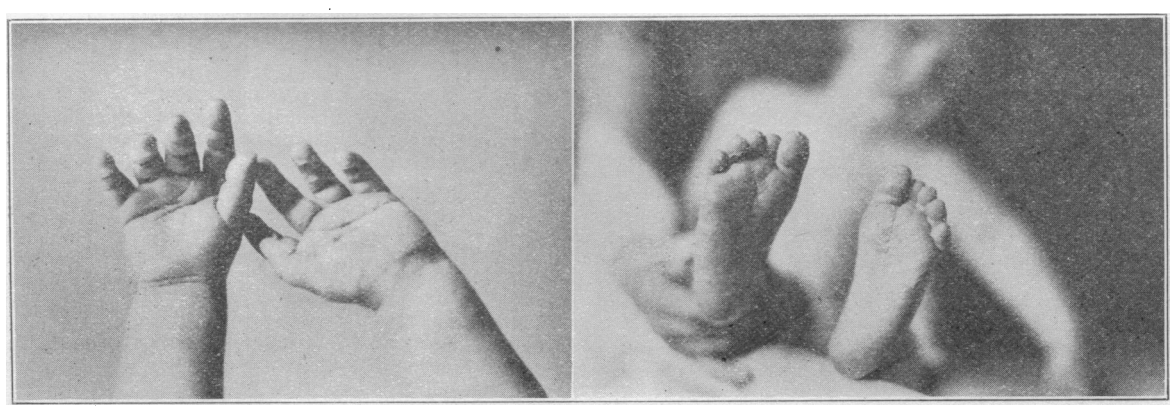
Since 1920, the American literature has contained reports of the disease syndrome called by Weston, "acrodynia." Swift of Australia, however, reported in 1914 a similar condition, which he called "erythroedema." Patterson and Greenfield state that the disease had been seen frequently in England prior to 1914. Its similarity to a disease occurring in Europe in 1828 is now admitted. Various names have been applied to the condition; that most generally accepted in the United States has been "acrodynia," which describes one of the symptoms, but one which might not always be acceptable. A more descriptive terminology would be that applied by Patterson and Greenfield, "erythroedema polyneuritis," as it emphasizes the underlying pathology.

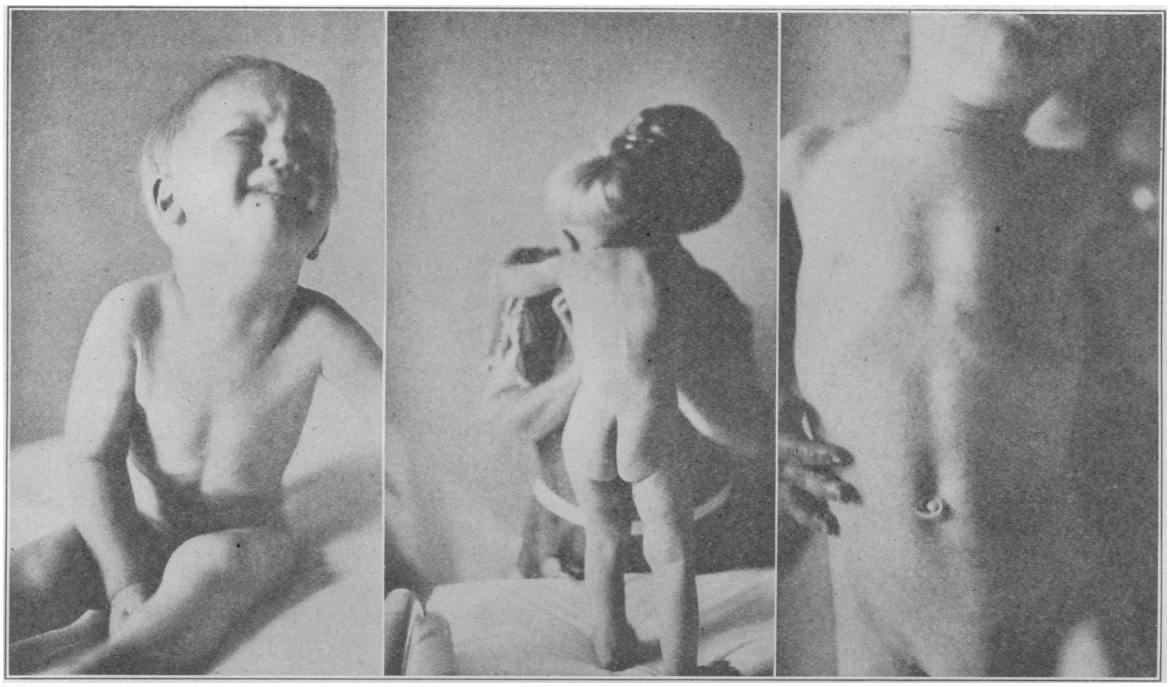
The value of individual reports is in tracing the geographical and climatic distribution. To our knowledge, cases have not been recognized as such in Southern California, although several patients have been seen around the San Francisco Bay region. Dr. Scott's report adds to our conviction that the disease has a widespread distribution. Whereas many of the cases previously reported have had a history of respiratory infection preceding, this case is without such a history. The rest of the clinical picture is classical.

ROBERT G. SHARP, M. D. (420 Walnut Street, San Diego)—While I, in nowise feel qualified to discuss acrodynia, except to comment on the rarity of its occurrence in southern California, I do feel entirely competent to commend Dr. Scott's paper in its entirety and to comment most favorably upon his report of this rare condition. I am heartily in accord with such reports. I am positive that we get enough and see enough of the ordinary stuff and believe that we keep ourselves up to date, alive, and progressive through refreshing our memories by the study of just such rare conditions as Scott has reported.

That acrodynia is rare in Southern California, I feel sure will be admitted without question. To its rarity in some parts of France, at least at certain times, I can also attest. During the war, I saw all of the hospital cases selected out of over a hundred thousand dispensary children from a population of between five hundred thousand and seven hundred thousand. This covered a period of twelve months. No cases of acrodynia was recognized among these children.

There have come under my personal care here in San Diego over six thousand children since the war, among which, I am also positive, no such cases have presented themselves. That I could not have overlooked a case of acrodynia seems certain to me, as I have had during





this time most clearly in mind the perfectly typical case presented by Dr. Lucas at the University of California Hospital. The picture was so striking, and the impression made upon me so vivid, that, to use the oft-quoted phrase from Weston's description, "such a picture of abject misery once seen will never be forgotten."

Most interesting is Rodda's report on the favorable effect tonsillectomies have in these cases. Apparently, all the writers are agreed that the condition of acrodynia is the result of an upper respiratory tract infection probably focalized in the tonsils and adenoids. At least, this is what I glean from the reports of Giffen, Squires, Sweet, and Rodda. I failed to find in any of the reports whether the quartz-light therapy had been used directly on the infected tonsils. Sweet, of course, reports that the whole of the body was exposed to the rays of the mercury vapor quartz lamp. It would be interesting to determine whether or not the quartz-light therapy, applied locally to the infected tonsils, might take the place of the tonsillectomies. Dr. Rodda's comment along this line would be worth while.

I thank Dr. Scott most heartily for calling my attention to the fact that acrodynia has occurred in Southern California, and I promise him that I will keep both eyes open and report immediately should any suspicious case come under my observation here in San Diego.

CLIFFORD SWEET, M. D. (242 Moss Avenue, Oakland, California)—Because I have seen but four cases of acrodynia, two of these through the courtesy of colleagues, I can add no discussion based on extensive personal experience. However, I feel that photophobia should be stressed as the symptom usually presented in such striking manner that one is led to think of this condition in making a differential diagnosis. Also if the teeth have erupted, looseness or actual loss of these organs may be the reason for seeking medical advice. At present we have a child under observation and quartz-light treatment, because of a very acute photophobia following an acute upper respiratory infection—no other symptom, except a constant desire to remain in bed, being present.

DOCTOR SCOTT (closing)—I wish to thank the doctors who have discussed this paper.

At the meeting of the Southwestern Pediatric Society on January 6, 1926, at which time this paper was presented, the discussion brought forth some new cases that had been seen recently but not reported—one case by Dr. Saphro; one by Dr. Berkley, and two from Long Beach, by Dr. Bliss, which shows that the condition is not as rare as it might appear to be.

Six points in the diagnosis have been mentioned by one of the Australian men, and they are the predominating symptoms: 1. Pain. 2. Pink hands. 3. Peeling. 4. Prostration. 5. Paresthesia. 6. Perspiration.

Opposition to Treatment by a Corporation — The Medical Society of the County of New York unanimously adopted the following resolution, May 24:

Whereas, It has come to the attention of this society that the New York Tuberculosis Association, Inc., as an inducement to obtain additional members therein, has made the following representations to the public, to wit:

"The New York Tuberculosis and Health Association, Inc., offers free information and advice on all health problems and expert chest examination with x-ray facilities at cost to employees of offices, stores and factories—arrangements made for placement in suitable institutions when necessary"; and

Whereas, It is understood that Mr. Harry O. Hopkins, director of the Association, has stated that the price of the expert chest examination with x-ray facilities is to be $15; and

Whereas, a Corporation is expressly forbidden to practice medicine by the laws of the state of New York; and

Whereas, Said representation made to the public leaves the cost of such proposed treatment vague and uncertain, although known to the association; and

Whereas, Such treatment, stated to be at cost, is to be given to a group of employees, irrespective of their ability to pay therefor, many of whom can readily afford to obtain such advice and treatment from their family physicians; and

Whereas, No provision is contained in such proposal to limit such treatment and advice to those persons referred to the Association by practicing physicians; and

Whereas, In the opinion of this society, such proposal, if carried out as made, would not be to the best interests of the profession or of the public; now, therefore, be it

Resolved, That the Medical Society of the County of New York is opposed to and protests against the carrying out of such proposal as made by the New York Tuberculosis and Health Association, Inc.

"A healthy mind in a healthy body" is the new slogan. But are good minds necessarily domiciled in healthy bodies? The history of the race does not prove it. There is something about a healthy body, apparently, that does not lure a good mind. It is probably too healthy. No; you cannot sort out intelligence by physical symmetry.—Clarence Darrow, American Mercury, June, 1926.